Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HUMPAL PHYSICAL THERAPY
5026 DEEPWOOD CIRCLE
CORPUS CHRISTI TX 78415

Respondent Name
Texas A & M University System

Carrier's Austin Representative
Box Number 29

MFDR Tracking Number
M4-13-1587-01

MFDR Date Received
February 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Humpal Physical Therapy just wants to get paid for the FCE text performed for this patient as ordered by her physician…"

Amount in Dispute: $660.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation requirements for an FCE were not met. The respondent maintains its position that CPT code 97750-FC was correctly denied in accordance with the TDI-DDWC rule 134.2049g)."

Response Submitted by: Starr Comprehensive Solutions, Inc. P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2012	97750	$660.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline procedures for workman's compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor provide documentation to support the level of service?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.204(g) states, "FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:
DWC Rules (2/17/2013) 28 TAC Chapter 134 20 of 68
(A) appearance (observational and palpation);
(B) flexibility of the extremity joint or spinal region (usually observational);
(C) posture and deformities;
(D) vascular integrity;
(E) neurological tests to detect sensory deficit;
(F) myotomal strength to detect gross motor deficit; and
(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:
(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:
(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing)."

Review of the submitted documentation finds all elements required by Division guidelines were not included within submitted documentation. Specifically;

1. Cardiovascular endurance was attempted utilizing "Step Test" not via a stationary bike or treadmill

The Division finds the submitted medical record does not support guidelines of 28 §134.204(g).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 13, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.